

INDUCERS OF EXPECTANCY FOR POSITIVE  
THERAPY OUTCOME IN A MILITARY SETTING

By

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by

Peter Jay Klugman

This dissertation is dedicated  
to all those who maintained faith  
during the past six years.

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Three variables that a client is likely to encounter in an initial clinical interview were varied in an analogue study under controlled conditions, to determine how these variables would effect client expectation of therapeutic gain. The three variables observed were dress, i.e., white laboratory coat versus military uniform; credentials, i.e., lavish display of certificates versus no display; and therapist's style, i.e., directive versus non-directive. The subjects were 48 male soldiers in their third week of basic training who were randomly assigned to the eight treatments in this 2 X 2 X 2 experimental design. It was hypothesized that those soldiers exposed to the white laboratory coat, the lavish credentials, or the directive style, under circumstances



that were not identified as treatment, would have a higher expectancy of therapeutic gain than those who were exposed to the other sets of conditions. It was further hypothesized that these conditions would be additive, and when two conditions existed for the same subject his expectancy would be higher than for one condition, and when a third condition was added expectancy would be even higher.

Three confederate counselors were utilized in this study and were not informed of the nature of the experiment or of the expected outcome. They conducted what was presented as an information gathering interview under the circumstances that were established for them. Each confederate served in each experimental condition two times in order to control for the possibility of a therapist effect.

Two measures of expectancy were devised to serve as the dependent variables. The first measured the subject's expectancy of personal improvement and the second, how likely it was that the subject would refer others for treatment. Both instruments were tested for internal consistency on a population of 61 newly arrived trainees at the Fort Dix, New Jersey Reception Station. Coefficient Alpha for the personal improvement variable was .95, and for the referral variable was .79.

A four-way analysis of variance was conducted on the personal improvement variable using three levels of the confederate variable. No significant main or interactive effects were noted involving the therapist. The data were then compressed to a 2 X 2 X 2 design and a three-way analysis of variance was conducted. There was a significant main effect attributable to therapist style which supported the hypothesis that the directive style would be a more powerful expectancy inducer in this setting than the non-directive style. There were no significant interactions. A similar four-way analysis of variance using three levels of the confederate variable was conducted on the referral variable. Here again there were no significant main effects attributable to the confederates, but there were significant interactions between confederate and style, and between confederate, style, and dress. There were no other significant main or interactive effects.

The results only supported the single hypothesis that in this particular population the directive therapeutic style is more likely to induce expectancy for personal improvement than the non-directive therapeutic style. There was no indication that dress or credentials had any impact as expectancy inducers.

An unanticipated result of this study that warrants further research was that the two dependent variables failed to correlate very highly with each other ( $r = .23$ ).

This leads one to ask the question of why an individual might feel that a particular therapist might be helpful to him, but still be reluctant to commend that therapist to a friend, or why he might send a friend to a therapist who he did not feel would be helpful to himself.

## CHAPTER I INTRODUCTION

### Problem

The "placebo effect" in medicine has been shown on numerous occasions, through rigorous research, to be a real force that must be reckoned with when evaluating new treatment modalities. The effect is so powerful that not only can it lead to inert substances reducing symptoms, but it can create new "symptoms." Placebo treated patients have complained of a wide range of "negative side effects" that include nausea, headaches, sleepiness, and reduced concentration (Zimbardo & Ruch, 1977). Haas, Fink, and Hartfelder (1959) even reversed the usual pharmacological effect of Ipecac by suggesting that it would reduce nausea of pregnancy. It has been postulated by many that it was expectancy set alone that accounted for many of the ancient cures brought about by early physicians, shamans, and witch doctors. Claghorn (1976) points out that from the time of Hammurabi there are documented evidences of "priest-doctors" who provided treatment consisting of medicinals, largely water, and incantations.

The role of expectancy as a curative was addressed by Freud (1964) in 1933 when he wrote: "And here I should like to add that I do not think our cures can compete with

those of Lourdes. There are so many more people who believe in the miracles of the Blessed Virgin than in the existence of the unconscious" (p. 152).

It was not until Rosenthal and Frank (1956) addressed the issue two decades ago in an article entitled "Psychotherapy and the Placebo Effect" that the "placebo effect" became an issue in psychotherapy outcome research. This article attacked previous research as treating the "placebo effect" as superficial and transient, and called for the serious consideration of this effect in future studies. They concluded that improvement under a special form of psychotherapy cannot be taken as evidence for (a) correctness of the theory on which it is based; (b) efficacy of the specific technique used, unless improvement can be shown to be greater than, or qualitatively different from, that produced by the patient's faith in the efficacy of the therapist and his technique.

I must point out that while results ascribed to the "placebo effect" cannot, in addition, be ascribed to a therapy technique, they are, in fact, still results and should not be discounted. Strupp (1976) has declared that the deficiencies in the circumstances surrounding therapy will predictably lessen optimal results and at times vitiate them completely. It appears that it would be beneficial to maximize the "placebo effect" whenever possible, or at the very least to assure that it does not work negatively.

It has been pointed out by Fiske, Hunt, Luborsky, Orne, Parloff, Reiser, and Tuma (1970) that expectancy is sufficiently important to be treated as a separate entity, and they further feel that positive expectancy seems a necessary condition to therapeutic effectiveness. While this belief has become almost axiomatic in psychotherapy, although disputed by Wilkins in a 1973a review article, Fiske, et al. (1970) pointed out that little systematic research has been done on the topic, and that it is important for an investigator to ascertain and report expectancy. In our present stage of methodology this is a difficult but important requirement. They go on to affirm that research is clearly needed on this whole topic. Little has been done in the years since Fiske, et al., made their observation that has shed any additional light on the role of expectancy.

### Literature Review

The literature on the role of expectancy in psychotherapy outcome has always revolved around the causative effects of expectancy and results are not unlike much of the results of other psychotherapy outcome research. The expectancy literature is divided between studies that support the premise that expectancy affects outcome, and those that do not. Only as recently as 1977 (Martin, Friedmeyer, Moore, and Claveaux) has it been suggested that the relationship which exists is predictive, but not

causative, and this study takes a different tack from all preceding research. Martin, et al., hypothesize the possibility that a relationship exists between expectancy and outcome that is not a causal relationship, but serves only as a prognostic indicator. They liken the expectancy state to some meteorological phenomenon that can be used to predict the weather accurately, but has no role in causing it. More will be said about this study later as it tends to deal effectively with some of the criticism of earlier studies, as well as to provide a different way of looking at the results.

Correlational studies. Lipkin (1954) investigated the hypothesis that the patterns of feelings which a client exhibits towards himself, the patterns of attitudes which he holds towards his therapist, and his perception of the therapeutic process all bear a relationship to the extent of change which he sustains as a consequence of his experience in therapy. His findings strongly suggest that the client who is positively oriented to the counselor and the counseling experience, and who anticipates that his experience in counseling will be a successful and gratifying one, undergoes more change in personality structure than does the client who has reservations about the counseling experience. I mention this study first not merely because it is chronologically the earliest study in this review, but

because it answers a main criticism directed towards other studies. This criticism is that the outcome of therapy is usually based on client report, and this is thought by many to be an invalid measure. In the Lipkin study, outcome was determined by pre- and post-therapy projective testing.

Other correlational studies were conducted by Friedman (1963), Goldstein (1960a), Goldstein and Shipman (1961), and Ulenhuth and Duncan (1968), and yielded positive significant correlations, while Brady, Reznikoff, and Zeller (1960), and Goldstein (1960b, 1966) failed to demonstrate an expectancy-effect correlation.

Friedman (1963) used a correlational approach to compare patient expectancy with symptom reduction. He first measured the subject's degree of symptomatology on a discomfort schedule and then measured how the subjects thought they would feel after therapy. The score differences were considered to be a measure of "expected reduction" or expectancy. After an evaluation interview was conducted, with no attempt at formal therapy, the subject completed the discomfort scale again. Subjects reporting marked improvement tended to have high levels of expectancy significantly more often than those reporting little improvement. Friedman's data indicated linearity of correlation between expected and reported reduction of symptom intensity, in contrast to a correlational study conducted by Goldstein and Shipman (1961) which reported a curvilinear relationship.



Friedman concluded his article by drawing attention to the fact that his results were found after only one patient-clinician contact. He suggests that expectancy of help is activated at the first patient-clinician contact and may be an important determinant of symptom reduction in neurotic outpatients.

The curvilinear relationship found by Goldstein and Shipman (1961) was also based on outcomes resulting from the initial interview only, but differed from the Friedman results in that the most improvement was associated with moderate initial expectancy. This study involved 30 neurotic outpatients and the significant curvilinear relationship was between the degree to which patients anticipate symptom reduction due to psychotherapy, and the symptom reduction they perceive as taking place during their initial interview. As Martin, et al., (1977) point out, this sort of relationship is consistent with the relationship that exists between motivation and performance variables, and may tend to support a causative hypothesis. The findings are, however, confounded by the fact that the study was not blind, and the motivational level of the therapist might have accounted for some of the lack of linearity.

A study using medical student therapists and 105 psychoneurotic outpatients (Uhlenhuth & Duncan, 1968) was conducted over a longer period of time (minimum of six interviews). A change score on a symptom checklist between the first and the last interviews was used as the dependent

variable and was correlated with the patient's level of optimism about the probable outcome of treatment at the outset as measured on a simple seven point scale. While the investigators found that an initial weighted depression score was most highly correlated with the patient's symptomatic change, greater general optimism at the outset about probable outcome of treatment contributed significantly to the prediction of the relief of symptomatic distress.

When research failed to demonstrate a correlation between expectancy and outcome (Brady, et al., 1960; Goldstein, 1960b, 1966) investigators attributed the failure to the procedures and measurements employed rather than to the lack of validity of the expectancy effect.

The main problem with these early correlational studies, as pointed out by Wilkins (1973a), was that in the majority of them the only measure of therapeutic improvement was client self-rating. I contend that since most of the patients were being seen voluntarily because of their perceived distress that their perceived improvement should be considered a significant indicator of therapeutic gain. Also, as mentioned earlier, Lipkin's (1954) positive results were based on projective measures of change. Brady, et al., (1960) did attempt to use therapist's rating of change, but failed to show a significant correlation.

Noncorrelational studies. Later experimental studies attempted to instill high and low expectancy of improvement

in the patient. The usual approach here was to provide the prospective patient with information that would lead him to believe that the treatment he was about to receive has been proven to be effective or was of questionable efficacy. In his 1973 review article, Wilkins points out that six experiments (Borkovec, 1972; Krause, Fitzsimmons, & Wolf, 1969; Leitenberg, Agras, Barlow, & Oliveau, 1969; Marcia, Rubin, & Efran, 1969; Oliveau, 1969; Oliveau, Agras, Leitenberg, Moore, & Wright, 1969) lend support to the positive effects of expectancy of gain and 11 (Bednar & Parker, 1969; Grosz, 1968; Imber, Pande, Frank, Hoehn-Saric, Stone, & Wargo, 1970; Krause, 1968; Marcia, Rubin, & Efran, 1969; McGlynn & Mapp, 1970; McGlynn, Mealiea, & Nawas, 1969; McGlynn, Reynolds, & Linder, 1971a, 1971b; McGlynn & Williams, 1970; Sloane, Cristol, Pepernik, & Staples, 1970) were unsuccessful. Wilkins failed to mention that expectancy set of the subject was assumed to be influenced by the experimenter's instructions, and no effort was made to actually measure the patient's level of optimism or pessimism as was done in the earlier correlational studies. I offer that the very fact that the subject participated in the treatment implies some level of positive expectancy and the degree is determined by many more subtle influences than a set of verbal instructions.

Wilkins goes on to point out that in the studies presenting evidence in favor of an expectancy effect the therapists were aware of which subjects had received which

set of instructions, and in the studies failing to support an expectancy effect interpretation the therapists were uninformed as to which expectancies subjects had received. This, of course, would imply more of a therapist effect than an expectancy effect. He further claims that there is no research evidence that the therapist's primary function is a catalyst for client expectancy, but freely admits to the possibility that such factors as prestige of the therapist, the decor of his office, and other "placebo effect inducers" may contribute to therapeutic gain. But here again he points out that just as "expectancy set" has emerged without empirical support, so has the concept "expectancy effect inducer."

The recent Martin, et al., (1977) study, in its attempt to eliminate some of the earlier methodological questions, kept all involved in their studies unaware of the hypotheses under investigation. They used objective and subjective measures of outcome, which included the MMPI, diagnostic interviews by two independent clinicians who were unfamiliar with the patient's problem and treatment, and a brief psychiatric rating scale by Overall & Gorham (1962). In all, they used 15 measures of improvement, 12 that reflected improvement in specific areas of adjustment, and three that reflected global improvement. Their results showed a significant linear relationship between the measures of expectancy and improvement.

With this additional information, it is difficult to dispute Wilkins' contention that there is some evidence, as shaky as that evidence may be, to support the concept of "expectancy effect," and perhaps we have put the cart before the horse by investigating that effect before determining what the inducers are, if in fact there are any.

### Hypotheses

It is not the purpose of this study to provide another look at the role of expectancy on outcome, but to look at some of the variables that might induce expectancy in order to lay the groundwork for rigorous future studies of "expectancy effect."

The variables that can effect expectancy are of course infinite and include such obvious things as instructions to expect positive results, such innocuous things as the location of the building in the community, the respect for the referral source, and perhaps even the past experiences of friends or relatives with psychotherapy. Rather than arbitrarily selecting some possible inducers for investigation, I selected variables that it was in my power to manipulate fully. These were variables that could be controlled in the therapeutic setting if they were found to be expectancy inducers.

Perceived expertness of the therapist by the client is suspected to have a heavy influence on therapy outcome, or

stated in the other direction, when the therapist is not perceived as an expert by the client, he is not likely to have much input in behavior change. Persons presented as a Nobel Prize winner (Brockner & Insko, 1966), a famous writer (Aaronson, Turner, & Carlsmith, 1963), a psychiatrist (Bergin, 1962), and a Ph.D. psychologist (Browning, 1966), obtained greater opinion change when they presented discrepant opinions than did persons with lesser credentials. Strong and Schmidt (1970) showed that subjects' perceptions of counselors as experts were influenced by objective evidence of specialized training, such as diplomas, certificates, and titles, as well as by reputation, and that these perceived experts had greater success in getting a subject to change a rating about himself than did the perceived nonexpert. In a later study (Strong & Dixon, 1971) it was shown that perceived expertness was even able to mask the effects that counselor attractiveness might have on outcome.

Counselor attire would also seem to have some influence on perceived expertness and this is probably the reason that practicum supervisors often suggest a tie and jacket as the most appropriate attire for a male trainee. Schmidt and Strong (1970) have shown that casual attire tends to be interpreted as a sign of inexpertness. However, it certainly seems that this could vary among subcultures and needs further investigation. The two primary attire options for a military therapist have been considered in this study as potential "expectancy effect inducers."

Without reviewing the entire therapy outcome literature, I feel I can state without argument that there is little empirical evidence to support one therapy as being more effective than any other when looked at without regard to the specific circumstances in which it is applied. However, the possibility that therapist's style may in itself induce expectancy, depending on the perceptual set of the client population, would be a reasonable place to begin looking at the effects of different therapeutic modalities.

The difficulty in dealing with induced expectancy is that the definition of this state tends to be circular. It was pointed out by Wilkins (1973b) that if subjects given high-expectancy instructions demonstrated greater improvement than subjects given low-expectancy instructions it could be concluded that: (a) the groups of subjects did indeed have different expectancies, and (b) the different induced expectancies were responsible for differential outcome. If subjects receiving high- and low-expectancy instructions did not differ in improvement, it may be concluded that: (a) the instructions were ineffective in inducing differential expectancies, or (b) differential expectancies were induced, but expectancy had no effect under these treatment conditions. The presence or absence of expectancy state is identified by the outcome which expectancy is said to produce.

For expectancy to stand as a valid construct, it must be identified by measures independent of the outcome which it is said to produce. This was attempted by Imber, et al. (1970), who found that their expectancy instructions produced very little change from the pre-instruction expectancies that subjects held about therapy. Grosz (1968) found that his instructions did establish different expectancy sets. However, expectancy state had no effect on therapy outcome. This brings us back to the basic issue of this study, which is that before we can view expectancy as a valid construct affecting therapy outcome, we must first know if it exists and how to vary its intensity.

This study was designed to investigate some of the aspects of an initial interview that might influence the perceptions of the client regarding the expertness of the therapist, and might therefore influence expectancy set. It was hypothesized that among the more powerful variables to be found would be client perception of therapist's experience, dress, and therapeutic style. In the military setting in particular, where uniforms and awards are part of every day life, and a directive management style is the rule, these aspects of a therapist might be reasonably expected to affect the patient's expectancy for therapeutic progress.

For the new recruit who perhaps for the first time is experiencing rigid discipline demanded by the military, a transient situational disturbance is likely to be



precipitated. The resulting ineffectual behavior often results in a referral to the Community Mental Health Activity for evaluation and treatment. The amount and direction of the aforementioned variables on the recruits' expectancy set is not known, but I hypothesize that it would be influenced as follows.

Display of credentials. Credentials of any sort, including military awards, civilian awards, certificates, memberships, and honors, are likely to influence the recruits' expectancy. These are the accoutrements that are often associated with expertness in civilian life, and that have even more meaning in the military. Very early the recruit becomes aware of the fact that many of the more "experienced," "expert" soldiers have ribbons and badges on their uniforms that he does not have. He further realizes that he is a long way from getting any of these for himself. I hypothesize that this discovery will generalize to any indication of accomplishment and will lead to the attribution of more power to those with a large number of visible credentials, and therefore to a higher expectancy for positive outcome.

Dress. The uniform options for military medical personnel are limited to the duty uniform or to white medical attire with a name tag. While the former connotes military expertness and authority, the latter indicates medical expertness, which is likely to be seen as more powerful for helping the recruit through a period of stress.

Counselor style. As Bednar (1970) points out, improvement happens as long as each counseling system successfully imparts to the client the expectation that he should be improving as a result of the expert treatment he is receiving and that success of psychotherapy is based on this as opposed to the specific counselor methods employed. If this is the case, therapist style itself may be a situationally determined "expectancy effect inducer." The therapist style most often used in the military is a motivational, rational, cognitive-behavioral style that is designed to support the recruit and give him direction. It is highly directive and resembles the rational emotive approach advocated by Ellis (1973) and the cognitive-behavior modification approach of Meichenbaum (1977). This provides for an immediate course of action, challenges the patient's current thinking, and is consistent with his perception of the military authority figure. I believe he will see the person with this therapeutic style as a more powerful helper than a more non-directive therapist. As pointed out by Staples, Sloane, Whipple, Cristol, and Yorkston (1976) research studies have not isolated those therapist behaviors that lead to improved outcome with sufficient consistency or precision. Even the apparently well-established triumvirate of accurate empathy, unconditional positive regard, and therapist's self-congruence is currently undergoing critical re-evaluation. While these need not be sacrificed in the directive approach, it is not felt

that they are sufficient unto themselves to induce an initial expectancy of positive outcome in an Army recruit.

Cumulative effect. It is further hypothesized that the expectancy effect inducers are independent of each other and will therefore be additive. Any combination of two or more of the heavily-credentialed, white-coated, directive therapist variables will induce a higher level of expectancy than any of these variables when presented in combination with the contrasting variables, i.e., no credentials, the military uniform, and the non-directive therapeutic style.

In summary the following specific hypotheses will be tested:

1. A lavish display of credentials in a military setting will induce a higher level of client expectancy for positive therapy outcome than no display of credentials in the same setting.
2. A military officer dressed in a white laboratory coat will induce a higher level of client expectancy for positive therapy outcome than will the same individual dressed in a military uniform.
3. An individual using a directive therapy style in a military setting will induce a higher level of client expectancy for positive therapy outcome than the same individual, in the same setting, using a non-directive therapy style.

4. The expectancy induced by the lavish credentials display, the white coat, and the directive style will combine additively.

## CHAPTER II METHOD

### Design

The experimental design used in this study was a complete three-way factorial with equal n's. The design consisted of eight cells defined by two levels of counselor credentials, crossed by two levels of dress, crossed by two levels of counselor style. Each subject participated in only one cell of the design while three confederate counselors each participated in each cell twice. When confederates were taken into account, the experimental design actually had 24 cells of two subjects per cell. The plan of the study was to rule out any effect attributable to the confederates and to compress the data into a 2 X 2 X 2 design with six subjects per cell.

### Subjects

The subjects for this study were 48 Army trainees who were in Basic Combat Training (BCT) at Fort Dix, New Jersey, in the spring of 1978. They were all in their third week of training and assigned to the same battalion. They were randomly selected from a pool of approximately 120 trainees. Three of the original selectees were

excluded from the study and replacements were selected from the same pool. Two of the excluded subjects were Spanish-speaking and could not read English, the third, a native-born caucasian, could not understand the instructions and later admitted that he could not read.

The subjects were randomly assigned to the experimental conditions and no effort other than randomization was used to control for the wide variety of backgrounds and experiences that can be ascribed to the thousands of trainees that annually attend BCT at Fort Dix. Brady, Zeller, and Reznikoff (1959) have shown that the factor of favorableness of conscious attitudes is not greatly dependent on commonly considered background and experiential factors.

Random distribution checks. As a check on the random distribution of subjects to experimental treatments a one-way analysis of variance was computed on the ages of the subjects. The null hypothesis could not be rejected at  $p < .20$  ( $F_{7,40} = .57$ ), and it shows that at least on this variable, the distribution was random.

As a means of checking if the subject population was in fact a cross-section of the country the subjects' home states were divided into nine geographic sections of the continental United States (World Book Encyclopedia, 1958). It was found that all geographic areas, and Puerto Rico, were included in the subject population with the exception of the mountain states.

These two checks were considered adequate demonstrations of the randomness of the assignment process.

### Confederates

The confederates in this analogue study played the part of counselors at the Community Mental Health Activity and were role-played by three individuals in the helping professions. All three were caucasian males with no gross differences in appearance. Their ages were 23, 31, and 35 with the two youngest being paraprofessionals and the oldest being a clinical psychologist with three years post-doctoral experience. Three confederates were used in order to provide a basis for generalizing the study's findings and at the same time every effort was made to reduce heterogeneity to rule out any main effects due to the confederates.

Prior to the study the confederates were thoroughly briefed as to what was expected of them. They were oriented as a group to the room setting, and were presented with a set of instructions (see Appendix A). The instruction packet included the instructions they were to give the subjects as well as the styles they were to affect. At no time were the confederates made aware of the dependent variable being measured or the hypotheses being tested. They remained blind to these conditions throughout the entire study.

A fourth confederate was used in the role of a receptionist. The receptionist was responsible for making initial contact with the subject, explaining the study to him, getting the consent form signed, and administering the dependent variable instruments. A more thorough description of the receptionist's duties, as well as the scripts used, is given later in the Procedures section.

### Independent Variables

The variables that were experimentally manipulated were clearly defined by the hypotheses to be tested and were easily controlled in the Community Mental Health Activity setting at Fort Dix.

Uniform versus laboratory coat. To test the effect of the military uniform versus the traditional white-garbed appearance of the health provider as an "expectancy effect inducer" the confederates wore a regulation Army khaki uniform by itself or covered by a full-length white laboratory coat. Most Army hospital staff members wear white laboratory coats over their regular duty uniform. To prevent contamination of the credentials variable, no decorations were worn on the uniform.

Credentials versus no credentials. The question of expertise as determined by some observable external source was presented to the subjects in the form of a lavish display of military and civilian awards framed and hung on the office wall. No attempt was made in this study to



differentiate between military or civilian awards and the display was either a lavish generalized one, or none at all.

The two experimental rooms were matched in all aspects and were mirror images of each other. The only difference was the single "credentials wall," which in one room had the lavish display and in the other had two large pictures. Photographs of these rooms are to be found in Appendix B, with a listing of the certificates displayed.

Directive versus non-directive. This final independent variable concerns the interviewing technique used by the confederate. To test the directive approach, the confederate attempted to change the subject's thinking about an issue on a minimum of one and a maximum of two occasions. At no time did he become abusive or provocative, and he always presented his ideas from a rational perspective, and on occasion, suggested behavior change to deal with problems presented by the subject. When using the non-directive style, the confederate tended to listen more than talk, supported the subject's rational statements, was more reflective, and attempted to get the subject to express all of his views on the issue. The instructions concerning style are included in the confederate instruction packet and are found in Appendix A.

### Dependent Variables

In order to test the hypotheses established for this

study it was necessary to have a measure of expectancy. Many such instruments have been devised but none were appropriate for the analogue design of this study, since the subjects had not been identified by themselves or others as patients, were not under treatment, and have not even been looking at the setting from a client-therapist perspective.

Most inventories designed to measure outcome expectancy were directed towards a patient with a specific problem or a long psychiatric history (Reznikoff, Brady, & Zeller, 1959; Goldstein & Shipman, 1961; Martin & Sterne, 1976; Martin, Sterne, & Hunter, 1976; Bloch, Bond, Qualls, Yalom, & Zimmerman, 1976). Dell (1977; Dell & Schmidt, 1976) had designed and used an expectancy questionnaire of an appropriate type, but it was designed for college students and included areas of concern about exams, choosing a major, and academic performance. Research as well as personal correspondence with Jerome Frank (1977), Arnold Goldstein (1977), E.H. Uhlenhuth (1978), and Don Dell (1977), failed to yield a satisfactory instrument.

For the purpose of this study it was necessary to design an expectancy questionnaire that would accurately reflect subject's expectancy level. It was decided to tap conscious attitudes as these tend to be related to therapeutic outcome to a significant degree, whereas subconscious attitudes as tapped by projective techniques

seem to bear no statistically significant relationship to outcome as rated by therapists (Brady, et al., 1959).

It was further felt that the cognitive approach to measuring expectancy is supported by the theoretical basis of client-centered therapy (Rogers, 1951) which has been confirmed by Lipkin (1954), and states that " . . . the individual behaves in accordance with his perception - that reality is for each individual the field as perceived . . . " (p. 29).

It seemed apparent to me that an individual's expectancy of outcome would be generalized to the extent that it would include expectancy for his own improvement as well as expectancy for the improvement of others. However, it also appeared apparent that while expectancy level may be the same there is a different risk level associated with a self-referral and a referral of a friend, relative, or other acquaintance. There is a difference between what one thinks and what one thinks others will think. For this reason, it was decided to evaluate these two contingencies separately, even though it was expected that the two measurements would behave in the same manner.

Personal improvement variable: The first instrument used was designed to measure the subject's expectancy for his own improvement. It contains 48 questions that are scored on a five point, Likert type scale (see Appendix 1).

The instrument includes areas of concern that might trouble a basic trainee. The areas of concern themselves

were selected from the Hopkins Symptom Checklist (Derogatis, Lipman, Rickles, Uhlenhuth, & Covi, 1974) and my experience as director of the Community Mental Health Activity at Fort Dix for approximately 18 months. It should also be noted that these items were reviewed by a committee of the University of Florida graduate faculty as a means of insuring their face validity. The entire instrument was then evaluated for internal consistency.

The evaluation of internal consistency took place in the following manner. A 40 minute stress inoculation lecture (Beach & Klugman, 1977) was presented to 61 trainees at the Fort Dix Reception Station. The trainees were then asked to complete the expectancy questionnaire anonymously after being informed that their cooperation was voluntary. Only 57 questionnaires were useable since four subjects failed to respond to one or more pages. The responses to the questionnaire were then evaluated using Coefficient Alpha as a measure of internal consistency (Anastasi, 1976). The statistical analysis resulted in a Coefficient Alpha of .95, which indicates an extremely high degree of item reliability. A matrix of the actual test scores can be found in Appendix G.

Referral variable. The second dependent measure, likelihood to refer, was designed in the same manner as the first and consisted of eight items (see Appendix F). Here Coefficient Alpha was .79 which is also an acceptable level of reliability. A matrix of the actual test scores can be found in Appendix G.

For both instruments the expectancy score was a single number representing the summation of the scores of each individual item. Highly unlikely was rated as 1, and highly likely as 5. The questionnaires were designed to discourage straight-line marking by alternating the direction of the scales. This was carefully explained to the subjects to avoid confusion.

### Procedure

A roster of trainees from A and C Companies of the First Battalion, Third BCT Brigade, was obtained and represents the subject pool. This roster contained the names of 119 men from which 59 were randomly selected for inclusion in the study. Eleven extra subjects were selected to allow for the possibility of some subjects not being able to take part in the study for various reasons. As it turned out, two individuals were excluded because of language difficulties and one, due to a reading deficiency.

A subject list was prepared assigning two subjects to each experimental hour. This was done in such a way to assure that the subject's company would not be in some crucial training phase that the subject could not miss or make-up. This system of assignment worked out well since during the five days during which the study was conducted, it was rare to find that both A and C Companies were undergoing critical training.

The experimental treatments (see Figure 1) were divided into two groups based on whether the credentials (treatments A, B, E, & F) or no-credentials (treatments C, D, G, & H) room was to be used. This was done to allow both rooms to be used at the same time to a maximum degree. Each treatment was then randomly listed six times, twice for each confederate. Since the total study took five days to conduct, this random presentation of treatments was used to control for the variables that were not a concern in this study such as the time of day, the day of the week, the weather, training the subject had just undergone, if he had guard duty the night before, etc. Each subject was assigned to the next treatment on the list as he arrived. Only when random selection resulted in the same confederate being assigned to both rooms at the same time was it necessary to lose a portion of an hour. On the occasions when this did occur, the lost time was made up with little difficulty by altering the schedule slightly.

All subjects were seated in a central waiting area and were allowed to read magazines and interact with each other. None had been informed of why they were there, or what they should expect. A check was made on this by asking each subject why he thought he was there, and virtually all of them claimed total ignorance.

Experimental treatment began when the subject was led into the appropriate treatment room where the question was

	CREDENTIALS			NO CREDENTIALS	
	LAB COAT	UNIFORM		LAB COAT	UNIFORM
DIRECTIVE	A	B		C	D
NON-DIRECTIVE	E	F		G	H

Figure 1. Experimental treatment groups.

posed if he knew why he was there. When a negative answer was received, the receptionist outlined the purpose of the study to the subject, informed him of his right not to take part, and directed him to read two framed sets of instructions (see Appendix C) on the wall. It must be noted at this time that the framed set of instructions was centered on the credentials wall and placed between the two large pictures in the non-credentials room. Before departing, the receptionist drew the subject's attention to the wall "decorations" as outlined in the script. The introductory script used by the receptionist is to be found in Appendix D.

The subject was then left alone for five to seven minutes to read the study description and instructions. There were no magazines or other reading material in the rooms, which were furnished as typical counselor's offices (see Appendix B).

After the waiting period, the receptionist re-entered the room and asked if there were any questions. If the subject consented to take part in the study he was offered a consent form for his signature (see Appendix E). When the consent form was signed, as it was in all cases, the receptionist went out to get the confederate who appeared wearing the appropriate dress for the experimental condition.

The two dress options, as mentioned earlier, were the Army khaki uniform, with name tag and without decorations, or the white laboratory coat with name tag. To insure that



rank was not a confounding factor, all confederates wore the rank of captain and the same name tag on their uniform. On the lab coat they all wore red name tags with white letters which included both the rank and the name.

Each confederate was then left alone with the subject and began with an identical set of instructions. The actual script used is included in Appendix A with the entire set of instructions that the confederate received on how he was to conduct his portion of the study.

At the termination of the interview the interviewer thanked the subject and excused himself to get the receptionist who administered the measures of the dependent variables.

The receptionist's instructions on the administration of the questionnaire are to be found in Appendix D with the entire receptionist's packet. The receptionist made every effort to assure that the subjects understood all aspects of the measuring instrument and that there was no question of confusion. Each questionnaire was explained separately.

After the questionnaires were completed each subject filled out a brief demographic data sheet, was thanked, and returned to his unit with instructions not to share what happened with anyone in the unit for the next seven days. It was explained that this was necessary to insure that the other trainees did not have an opportunity to formulate opinions before their interview or to be contaminated by the opinions of others.

Since virtually none of the trainees reported knowing what to expect when they entered the experimental setting, apparently the early subjects refrained from discussing their experiences with those who entered the study later.

## CHAPTER III RESULTS

### Method of Analysis

For the analysis of the data, the experimental cells were arranged in a 2 (credentials) X 2 (dress) X 2 (style) design. Each of the dependent variables was tested separately using analysis of variance to first rule out the possibility of a confederate effect and then to test for significant effects attributable to the independent variables.

### Dependent Measures

Personal improvement variable. A four-way analysis of variance was conducted using three levels of the confederate variable to determine if there was any effect that could be attributed to the confederates. To insure that a type 2 error, i.e., not rejecting the hypothesis of zero interaction when it should be rejected, was kept numerically small, these preliminary tests were made at a numerically high type 1 error,  $\alpha = .20$  (Winer, 1962). This preliminary testing indicated no significant confederate effects (see Table H-1).

Having found no confederate effects, it was considered appropriate to adjust the model by compressing it to a 2 X 2 X 2 design, and to conduct a three-way analysis of variance (Winer, 1962). As indicated in Table 1, there was one significant main effect which was attributable to therapist style. There were no other significant main effects or interactions.

Further analysis of the main effect for therapist style indicated that the directive style (mean for all subjects equals 177.25) was more effective than the non-directive style (mean for all subjects equals 158.25) in inducing expectancy on the personal improvement variable. Summary tables of the mean scores for this dependent variable are located in Appendix I.

Referral variable. As with the personal improvement variable a four-way analysis of variance was conducted using three levels of the confederate variable to determine if there was any main effect that could be attributed to the confederates. Again, efforts were made to keep the possibility of a type 2 error numerically small,  $\alpha = .20$ . There was no main effect attributable to the confederates. However, there were significant interactions between confederate and style ( $F_{2,24} = 4.26$ ;  $p < .20$ ), and between confederate, dress, and style ( $F_{2,24} = 2.31$ ;  $p < .20$ ) (see Table H-2).

Scrutiny of the confederates and style interaction indicated that confederate A was more effective in getting

Table 1  
Summary Table of Compressed Data for  
Personal Improvement Variable

Source	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>
Setting (A)	96.3	1	96.3	.15
Dress (B)	705.3	1	705.3	1.10
Style (C)	4332.0	1	4332.0	6.78*
A x B	243.0	1	243.0	.38
A x C	645.3	1	645.3	1.00
B x C	21.3	1	21.3	.03
A x B x C	507.0	1	507.0	.79
Error	25560.7	40	639.0	

\* $p \leq .025$

a subject to report that he would refer a friend, when using the non-directive therapeutic style. Confederate C was more effective when using a directive therapeutic style, and the effectiveness of confederate B was not differentially effected by the style he used (see Figure 2).

When dress was added to form a three-way interaction between confederate, style, and dress, it became even more obvious that the effect of the style variable and the style X dress interaction was idiosyncratic to the experimenter, and therefore the effect of the style and dress variables were uninterpretable (see Table 2). The credentials variable showed no significant main or interaction effect and as a result there were no interpretable effects on this dependent variable.

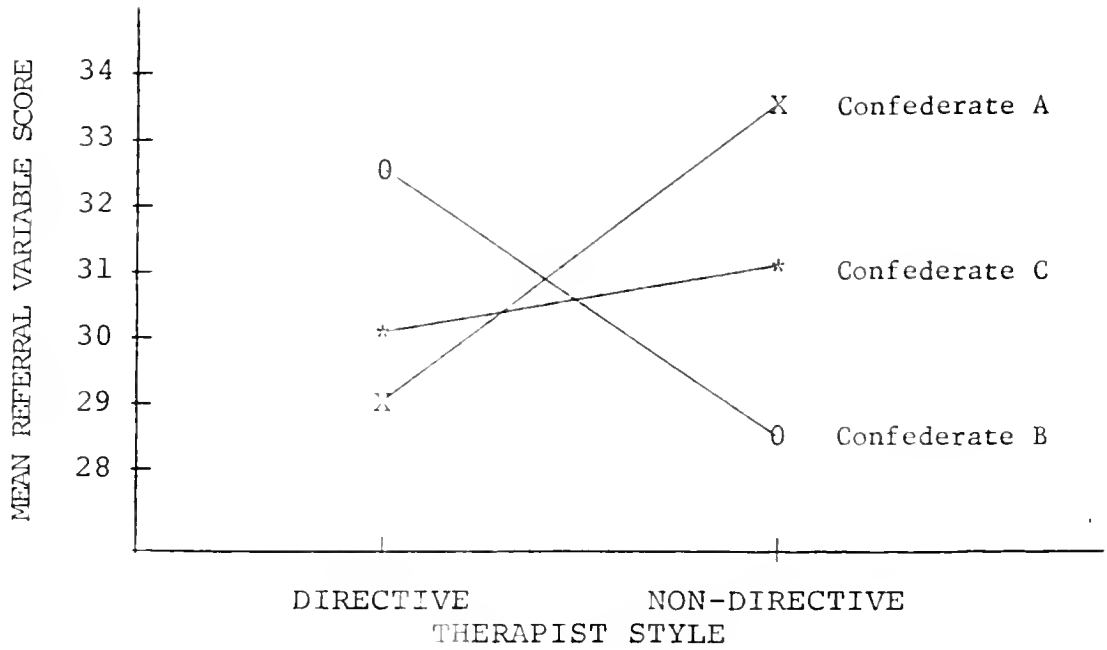


Figure 2. Likelihood to refer a friend as a function of therapist style and confederate.

Table 2  
Summary Table of Mean Scores on the Referral Variable as a  
Function of the Confederate X Style X Dress Interaction

CONFEDERATE	Uniform		Laboratory Coat	
	Directive	Non-directive	Directive	Non-directive
A	27.3	34.8	30.8	32.0
B	33.0	27.0	31.8	33.3
C	30.5	29.5	29.8	33.3



## CHAPTER IV DISCUSSION

The anticipated superiority of the credentials over the non-credentials and of the white laboratory coat over the military uniform was not observed. This would seem to imply that these two variables have little or no independent impact on the development of expectancy set, for self or others, in male Army basic trainees. Since there were no significant differences observed, it could be hypothesized that development of positive expectancy for therapeutic outcome is not influenced by what appears to be some of the more obvious indicators of expertise.

The results of these data appear to run counter to research cited earlier showing that changes of behavior and perceptions are affected by perceived expertise. This might very well be the result of the unique nature of the military setting and the three weeks of indoctrination received by the trainee subjects. At this point in training, the trainee has already been pushed to his physical limits on many occasions, has been denied the right to speak his mind, and has been discouraged from thinking for himself or acting independently. He has begun to become part of a team and is being trained to

function as a single cell rather than as a unique organism. I suspect that in order to deal with the dissonance associated with giving up personal rights and freedoms, the trainee must believe that this is all being done for his own good, and that individuals directing him know what they are doing. This in turn could logically lead to the belief that everyone has been certified as able to do the job for which he has been selected and ergo possesses the necessary level of expertness. If this is so, additional indicators of expertness may just be redundant. Is the individual introduced as a Nobel prize winner seen as more prestigious if he has a certificate stating this fact on his wall? This possibility is supported by the fact that the mean for the referral variable was 30.8, and the mean for the personal improvement variable was 167.8. The possible range of scores for the referral variable was 8 to 40, and for the personal improvement variable 48 to 240. On both variables the obtained mean scores were on the positive side of the scale. This implies a positive expectancy level for the group and supports the possibility that there was already an existing level of positive expectations.

These results suggest the need for a study that looks at expectancy change based on a pre-test, post-test design to insure that the population being scrutinized does not already have a skewed expectancy set. It would be interesting to see if a change score emerges as a post-

test, when a pre-test indicates that an individual has a negative or neutral expectancy. However, a suitable set of instruments for making such a test must first be developed.

Another area for research of this nature might be to compare baseline expectancies of various populations such as first-week basic trainees and seventh-week basic trainees, or basic trainees and high school seniors, as expectancy may be more a facet of experiential history than of a belief system that is supported or refuted in a single visit. The main question here seems to be, what makes an expert? One of the original premises of this study was that "doctors," or white-coated individuals, would be seen as more powerful healers than individuals wearing military uniforms. This was based on the belief that there is an experiential set that doctors are experts at helping others. The basic trainee may very well have developed an expectancy set unique to his population, where all military personnel are seen as qualified and expert in their job. The confederate might have been viewed as a qualified counselor hired by the army, as opposed to the officer-doctor dichotomy that was predicted.

Another area for investigation is the possibility that expectancy is not significantly influenced in a single session. Friedman's (1963) findings suggest that expectancy of help is activated at the first patient-physician contact, and Lennard and Bernstein (1960)

support the idea that a single session can be seen as a miniature reflection of the overall therapeutic series, expectancy, like the neurosis may incubate over time. If one develops a slight negative or positive set this may not be blatant enough to show up early, but may become more clearly defined over time.

The one manipulated variable that did have a significant effect acted only on the personal improvement variable and not on the referral variable. This was the directive as opposed to the non-directive style. This suggests to the author that style did not actually effect expectancy due to the dynamic suggested in the original hypothesis, that is that the directive therapist is seen as a more powerful helper. The possibility now emerges that expectancy for improvement existed regardless of the manipulated conditions and the subject merely "liked" the directive confederate more because he was more active in the discussion. The reason that this was not reflected on the referral variable could be that the subject was not willing to risk that the individual whom he "liked" would be "liked" by someone else. However, the confederate interactions that did emerge support the possibility that there is a personality component that should be considered.

Regardless of the reason, it is a fact that there emerged a real distinction between subjects' expectancy for personal improvement and willingness to refer others. The correlation between the two dependent variables was

only .23. While the possibility that these two variables would behave differently was suspected it was surprising to find them so divergent. This opens a whole area of study into the risks patients associate with therapy and with how much value they place on a therapist they were sent to see as opposed to one they find themselves. An interesting question for future study might be to see if expectancy level differs for self-referrals as opposed to those referred by others.

## CHAPTER V CONCLUSIONS

The fact that expectancy level did vary as the result of the style affected by the confederate lends support to the belief that expectancy is a valid construct that can be manipulated in the therapeutic setting. The fact that it was measured by an instrument that was independent of the outcome which it was expected to produce further supports expectancy as an entity to be considered in therapeutic intervention. However, the fact that expectancy was differentially induced as a result of the style used does not necessarily mean that it is a condition essential to therapeutic effectiveness. Based on the results of this study this possibility is still not ready for testing, nor are we ready to evaluate the claims made by other researchers as to the effect of expectancy on outcome. While this study showed that style can effect expectancy, the other methods that may be used to induce expectancy with any consistency are still not clear. Since the induction of expectancy and the measurement of its degree and direction are tasks that have not yet been accomplished satisfactorily, psychology still seems to be ill prepared to investigate

the role of expectancy on therapeutic outcome. It is essential that the characteristics of the population being investigated be scrutinized to isolate the other external variables that might prove to be powerful expectancy inducers.

This study has provided little evidence to support the possibility that expectancy for positive therapy outcome is a function of the widely accepted expectancy inducers such as the perceived expertness of the therapist. While these results may very well be population specific, further research is required to test this possibility.

This study has made it clear that the induction of expectancy of positive therapeutic outcome is not as easily accomplished as some investigators would imply. Merely telling the client that one therapy style or one therapist is better than another does not necessarily mean that a differential outcome expectancy has been induced. It is still necessary to determine what the inducers are for the population being treated, if in fact there are any, and how to measure whether or not they have induced some level of expectancy.

This study has provided some groundwork for basic research in this area by developing a scale, and obtaining some data for comparison, that might be used in other studies of a similar nature.

In conclusion, as Claghorn (1976) pointed out, the "Priest-Doctor" role is no longer an adequate model for psychotherapy. While psychology and medicine should not discount the non-specific therapeutic effect of expectancy, the inducers may be so diverse, that research time and money might better be spent on the more specific therapeutic interventions applied to the identifiable areas of human distress and personal dysfunction.



APPENDIX A  
CONFEDERATE'S INSTRUCTIONS

Subject Instructions by Interviewer

The interviewer, after being introduced, will offer his hand to the subject and will then ask the subject to please be seated. He will then explain what is about to happen as follows:

"This study that we are conducting actually has two parts; the first part is concerned with learning more about your view of the operation at the Fort Dix Reception Station, and we'll learn this by having a brief interview with you and other trainees in your company. If you don't mind, I would like to tape record this interview so that I won't have to take notes. But, if the tape recorder makes you uncomfortable, just let me know and I won't have to put it on. The second part of this study involves gathering some information that might help us in improving the services of the Community Mental Health Activity here at Fort Dix, and this part will be in the form of a questionnaire that you will be asked to fill out after the interview. Do you have any questions?"

It is not anticipated that there will be any questions at this point, but if there are, they will be answered briefly and honestly. The interviewer will then turn on the tape recorder and begin the interview.

"I would like you to begin by telling me about your experience during your assignment at the Reception Station here at Fort Dix. Anything that happened, from the time you arrived to the time you were assigned to your basic training company that you found to be pleasant and satisfactory, or unpleasant and unsatisfactory is important. Some of the things you might want to cover would be how you were greeted upon your arrival, your first night, issuance of military uniforms, whether you felt like you had enough time or not enough time to get things done, and things that you really do not think should be changed, and things that you really would like to see changed in the operation of the Reception Station. Please go ahead."

If the subject is reluctant to speak freely, or claims that everything went well and he really has nothing to say, conversation may be stimulated with one or more of the following remarks:

1. "Do you feel that a week is enough time to spend at the Reception Station, or should it be extended by a few days?"
2. "What did you do during your spare time? Were you allowed to watch television, read books, go to the PX, or were you restricted to the barracks?"

3. "How did you feel about not being able to call home?"

4. "Was there anybody there you felt you could talk to if you were feeling homesick and had a need to talk to somebody?"

5. "Was there a chaplain available, and did he spend much time with your group as they moved through the Reception Station?"

6. "How did clothing issue go?"

7. "What would you like to see changed that would make the Reception Station experience a little more enjoyable?"

8. "I'm told that some people change their mind about being in the Army after being at the Reception Station for a while. What about the Reception Station do you think causes this?"

9. "How were the meals, and was the meal time experience pleasurable?"

After about 20 minutes the interviewer, after having played the proper role called for by the experiment itself (see style instructions), will terminate the interview and ask the subject if he has anything else to add. He will then thank the subject for his assistance and inform him that there is now a brief questionnaire that they would like him to fill out and that he will send the receptionist back into the office. He will then turn off the tape recorder, remove the tape, and leave the room, closing the door behind him.

### Style Instructions

After providing the basic instructions to the subject, the interview will commence. The therapist will be sitting in the chair by the desk facing the door, and the subject will be sitting in the chair located in the corner facing into the room. The therapist will use maximum eye contact during the entire interview, and one of the following interview styles.

#### Style 1: Non-directive

In the non-directive experimental setting, the therapist will support the subject's rational statements, will be reflective and empathetic, and will encourage the subject to express all of his views on the issue at hand. He will not attempt to influence the subject's thinking in any manner, and will tend to listen more than talk. He will communicate to the subject that he is actively listening through the use of non-verbal cues, such as maintaining eye contact, nodding agreement when appropriate, sitting comfortably but not sloppily, and leaning towards the subject on occasions when appropriate. Active listening can be conveyed verbally without introducing new information or questions by responding to

what the subject is saying. Ways of doing this include feeding back the last part of the subject's communication to let him know that he was heard, use of phrases such as "Yes, go on," "I see," "I understand," and "mmhm."

Following this set of instructions is some additional guidance to assist you in reflecting subject feeling and content.

### Style 2: Directive

Under this experimental condition, the confederate is free to present his own views to the trainee. On a minimum of one occasion, and on no more than two, during the brief interview he will make an active attempt to change the trainee's thinking on an issue. At no time will the therapist become abusive or provocative, and he will always present his ideas from a rational perspective, and might even suggest behavior changes to assist the subject in dealing with the particular problem. As in Style 1, the therapist under this condition will also be an active listener who will attempt to get the subject to express all of his views on the issue. Again, the key difference is that on a minimum of one, and a maximum of two occasions, he will attempt to get the subject to change one of his views.

### Reflections of Feeling and Content

Reflection is a technique used by a counselor to express in fresh words the essential feelings or ideas expressed by the client. This technique helps the individual to go below the surface of the words he uses and become aware of obscure, or perhaps unconscious feelings associated with those words. In other words, reflection helps the individual to get his feelings or ideas out front where both he and the counselor can better look at them. In addition, it lets the client know that the counselor is "with him" and understands where he is coming from.

### Difficulties in Reflecting

Stereotyping. Unvaried use of introductory phrases such as "you feel." Some variations are: "you think," "you believe," "it seems to you," "as I get it," "you felt that," and "I hear you saying."

Timing. Waiting for the client to stop talking before reflecting is not always correct. If something important comes up, it is alright to interrupt.

Selection of feeling. The client may express several feelings. The counselor must choose the most important feelings that need clarification.

### Four Errors of Reflection

Reflecting verbatim. This means giving back the identical words used by the client. Reflect underlying feelings and ideas, attitudes, etc.

Inappropriate depth of feeling. Reflect the same degree of emotion used by the client. Don't be too shallow or too deep in depth of emotional reflection.

Changed meaning. Don't add to or take away from the meaning of the client's words. Listen to what he says and don't read something into or out of his statements.

Inappropriate language. Respond to the client's frame of reference. Use language he can understand and relate to. There is a limit, however, as to how far you can go with this.

### Summary Reflection

This is similar to reflection as described previously except that it brings together several feelings and/or ideas into a meaningful whole.

### Benefits of Reflection

1. It helps the client to feel really understood.
2. It helps the client to look at his feelings, attitudes, and ideas more objectively and thus understand himself better.
3. It helps to clarify the client's feelings and ideas.

APPENDIX B  
PHOTOGRAPHS OF EXPERIMENTAL SETTINGS



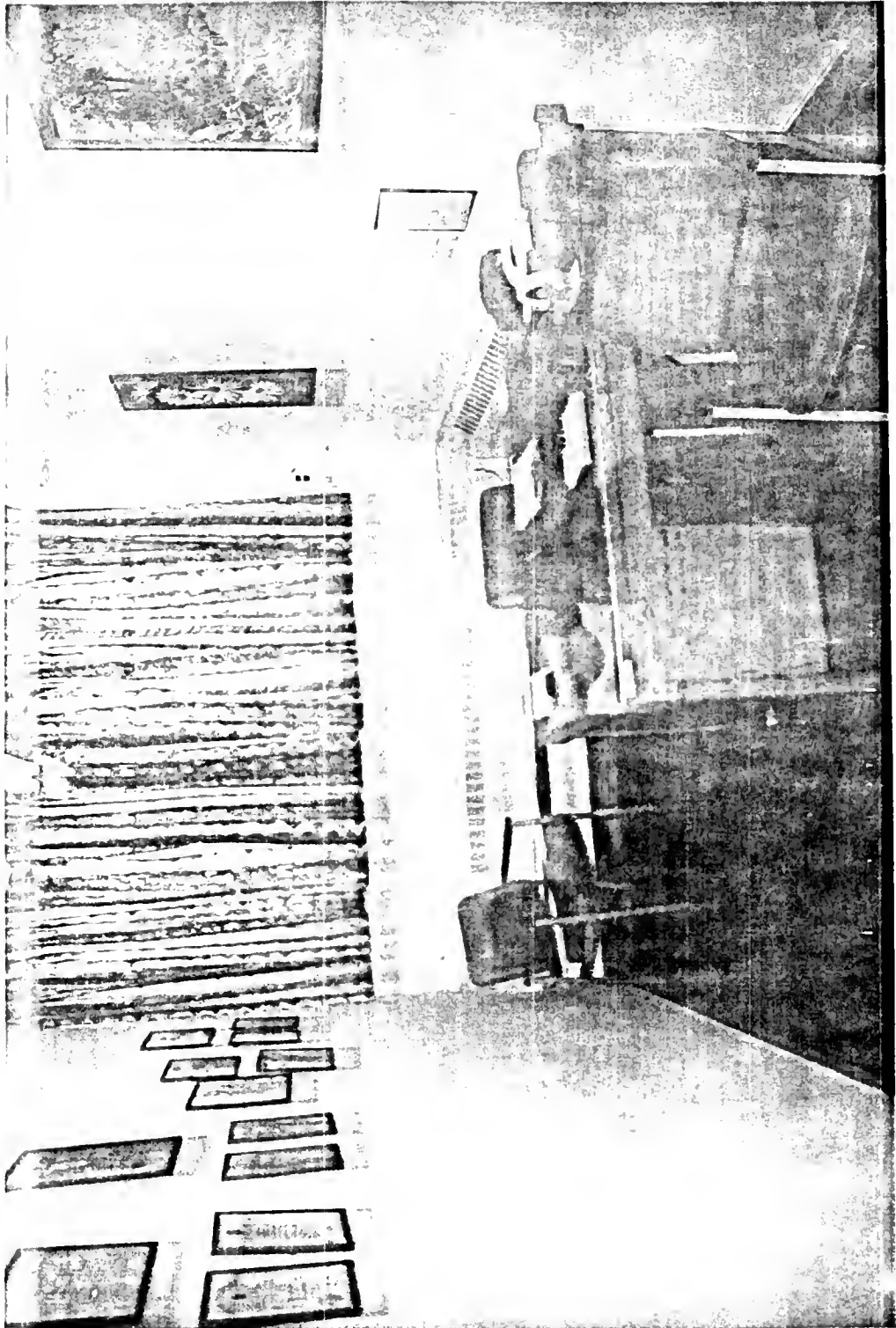


Figure B-1. View of the credentials room from the front.

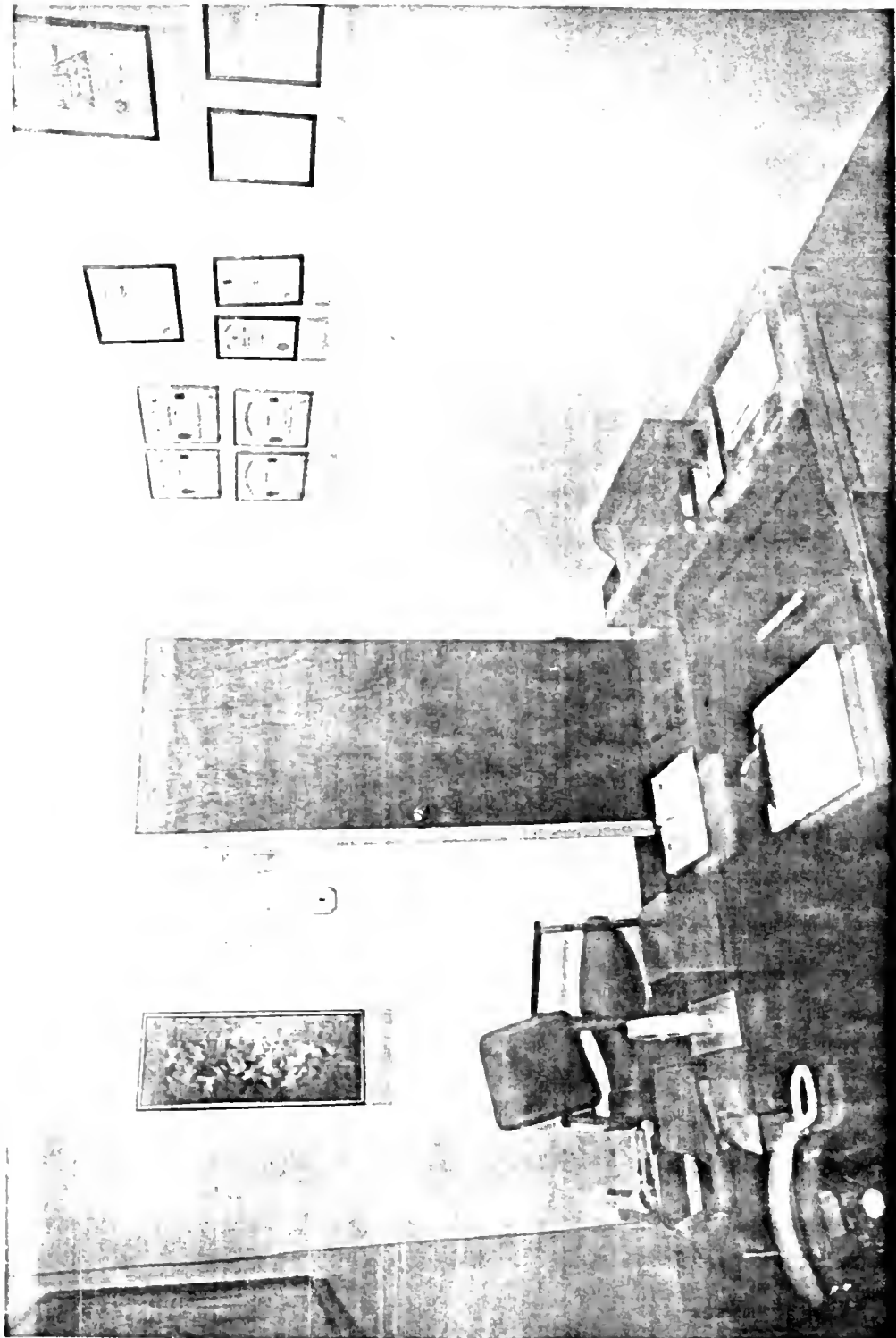


Figure B-2. View of the credentials room from the rear.

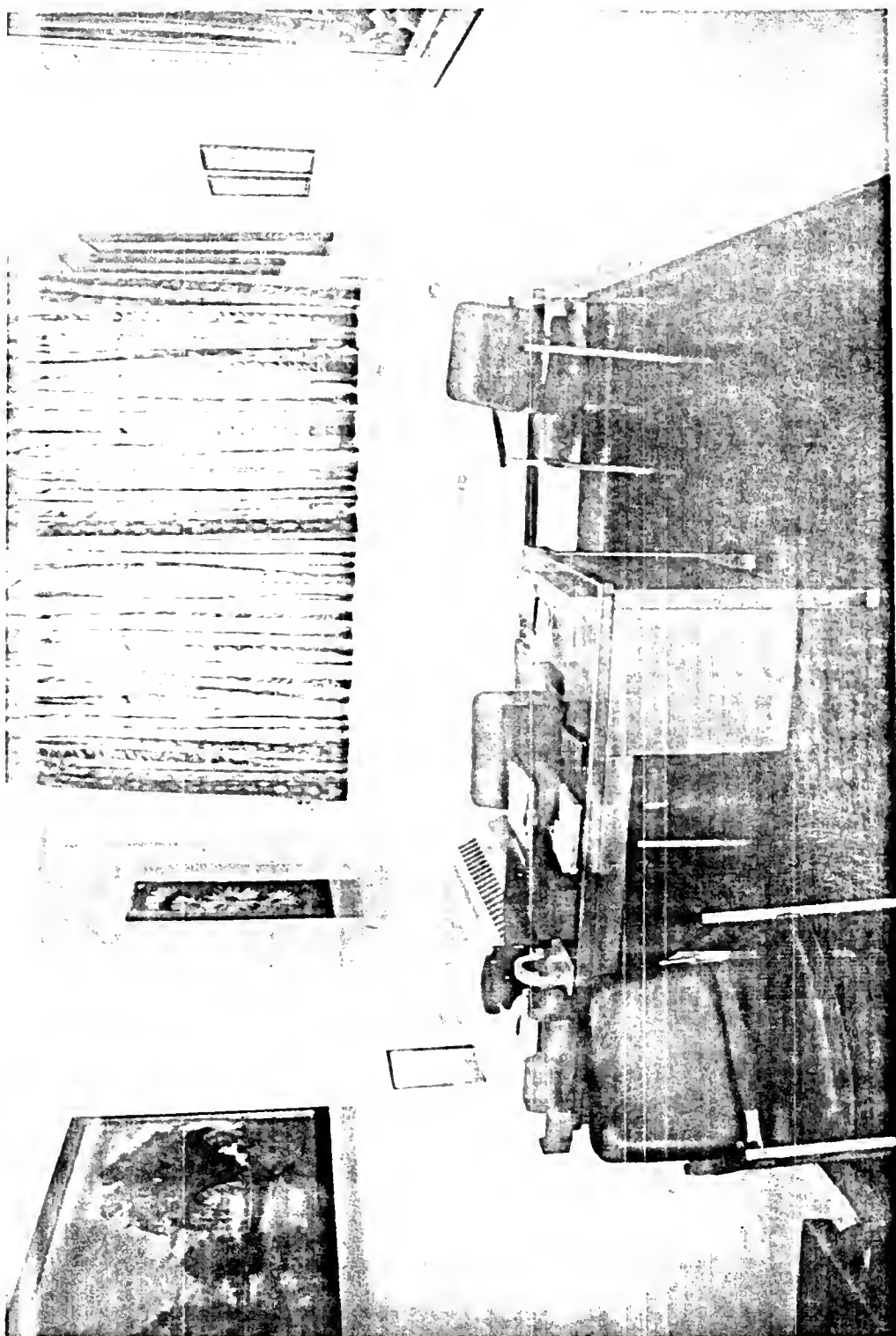


Figure B-3. View of the no-credentials room from the front.

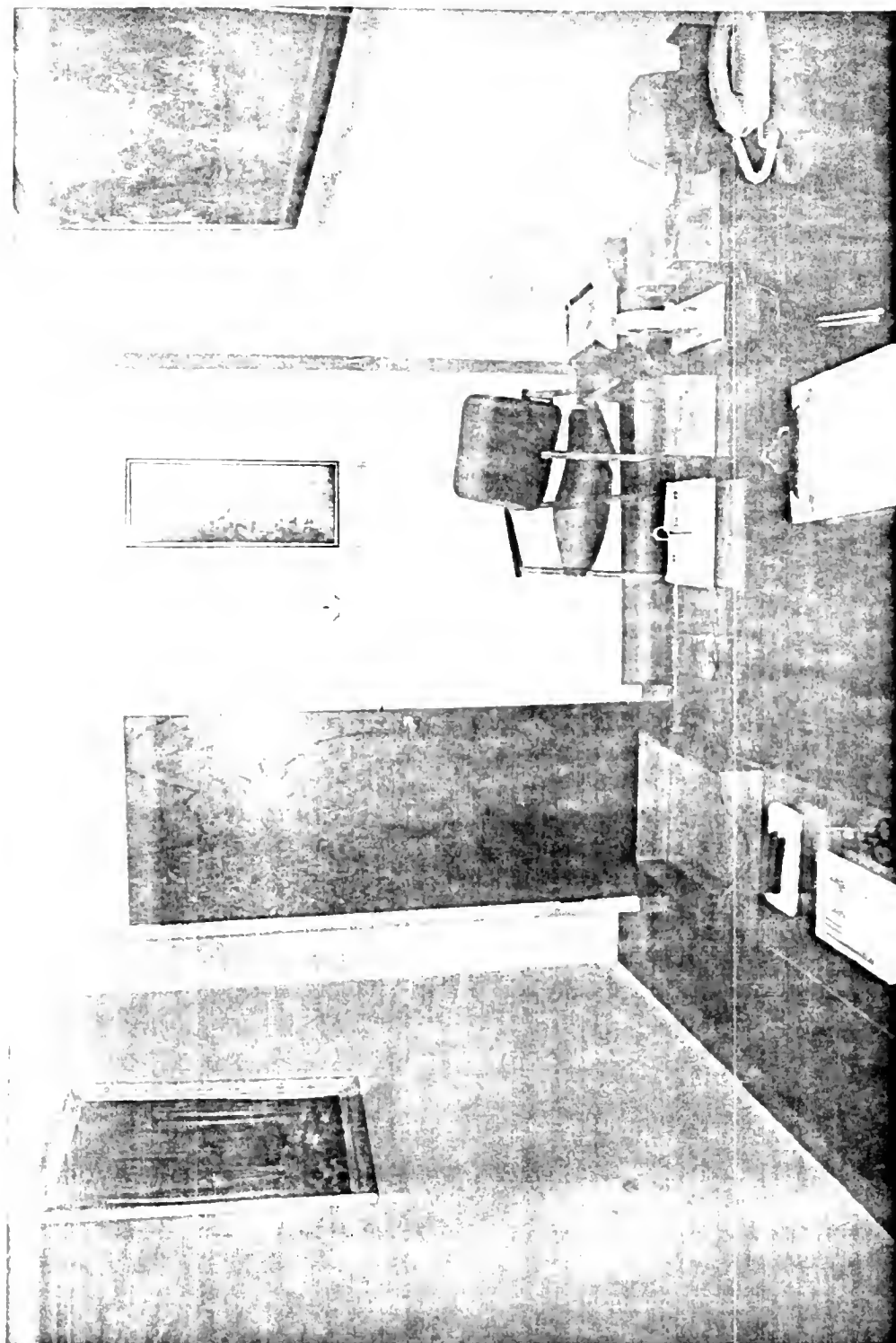


Figure B-4. View of the no-credentials room from the rear.

APPENDIX C  
POSTED INSTRUCTIONS

## STUDY DESCRIPTION

The purpose of this study is to gather information that will assist the Fort Dix Reception Station in improving their processing procedures and in gaining knowledge that will assist the Community Mental Health Activity in better dealing with some of the psychological problems that basic trainees encounter. In this study you will be given a brief interview and asked to complete a short questionnaire. The entire procedure will take less than one hour and each person will be interviewed and will fill out the questionnaire privately. Any information you give in this interview and questionnaire will be held in the strictest confidence and any reference to the results of this study will be in general or statistical form, which cannot be traced back to you. While we would like you to answer all of the questions, you may refuse to answer any that you wish. If at any time you wish to withdraw from the study, you may do so without any prejudice whatsoever.

### INSTRUCTIONS

You have been selected to take part in a study that is designed to get your views on the processing procedure at the Fort Dix Reception Station. Following is information concerning this study that may be of some use to you.

1. Your interviewer is a behavioral science professional on the staff of the Fort Dix Community Mental Health Activity.
2. The counselor is interested in your views and expects you to take an active part in the discussion.
3. Everything you say is confidential and nothing will be passed on to be used for or against you.
4. The interview will last for about 20 minutes.
5. The meeting will be recorded so that the counselor will not have to take notes. This will not be done if you object.
6. After completion of the interview you will be requested to complete a brief questionnaire.
7. If you have any questions, please ask the counselor before the interview begins.

APPENDIX D  
RECEPTIONIST'S INSTRUCTIONS

Introductory Instructions by Receptionist

The receptionist will escort the subject to the appropriate room and provide him with basic information and instructions as outlined below in the following narrative.

"You have been chosen to take part in this voluntary study because you are a basic trainee who has the sort of information that we feel will be useful in improving some of the Army's services. You are not required to take part in this survey, and if at any time you want to stop all you have to do is say so. We are interested in your views, but you do not have to give them if you do not want to. Nothing you say or do, or fail to say or do, will ever be used for or against you in any way. This piece of paper (Study Description) will help to explain more fully what this study is all about. This piece of paper (Instructions) will explain the way the study will be conducted. Please read them over carefully and I will be back in five minutes to answer any questions you may have." (The following is said in a light, jovial manner.)



"If you finish reading the two sheets before I get back feel free to read the walls (look at the pictures), while you wait."

The receptionist will then leave the client alone in the room to read the framed instructions, that have been pointed out to him, for a period of five to seven minutes. During this time the subject will be left alone in the room with the door shut. After the necessary time period has elapsed, the receptionist will return and ask if the subject has any questions. At this time questions will be answered and the receptionist will have the subject sign a consent form. Responses to questions will be as brief as necessary to satisfy the subject, and any specific questions about what will happen in the study will be answered by explaining that he will be asked some questions about his experience in the Reception Station and asked to fill out a brief questionnaire when it is over. It is anticipated that questions about the nature of the study will include the following:

Q. "Do I have to do this?"

A. "No, this study is voluntary, but we are interested in your answers, and nothing will be used against you."

Q. "What are you going to do with my answers?"

A. "We will use your answers to help improve the operation of the Reception Station and the Community Mental Health Activity. We are not really so much interested in your individual answers as we are in the general comments obtained from everyone. You will never be personally identified as having made any

particular statement, and it is very likely that our results will not even be all put together until you are graduated and no longer in training at Fort Dix."

"Now that you understand a little about what is going to happen, please read this form, and if you voluntarily wish to participate in the study, sign it at the bottom, indicating that you do volunteer."

After the subject signs the consent form, the receptionist will excuse himself and tell the subject that he will go get the interviewer. At this time he will leave the room, close the door, get the interviewer, escort him back to the experimental office, and introduce him to the subject. The receptionist will insure that the subject sits in the seat that provides a view of the entire room by stating; "Would you please sit in this chair, as the tape recorder picks up better over here."

### Questionnaire Instructions by Receptionist

The receptionist will re-enter the testing room and will have in his possession all questionnaires to be used, to include a demographic data sheet. He will offer the subject a seat behind the desk where he can be comfortable and have a hard writing surface. At this time, he will explain the questionnaire.

"We would now like you to fill out two questionnaire forms that I will explain to you. The forms appear to be the same, but are really very different, and may appear to be a little confusing. If you have any trouble with the instructions, be sure to ask me to explain them to you again before you begin. First, let's read the instructions together. On the scale below, that means these series of lines (he points out the scale) put an "X" in one of the spaces after each question, to indicate how likely it is that the counselor you have just seen, that was Captain Klugman who just interviewed you, could help you if you were experiencing one or more of the following concerns. It is very important for you to understand that we are not saying that you do have these concerns, or that you ever will have these concerns. The question we are

asking you is, IF you were experiencing one of the concerns listed below (receptionist indicates list of concerns with his finger) how much do you believe that the man you just saw could be of some help to you in dealing with those concerns? Note that the scale has a range from highly UNlikely that he could be of help to you to highly LIkely that he could be of help to you. You may mark anyplace along that scale to indicate how much help you think he would be. Also note that the scales are mixed up with highly likely and highly unlikely being switched around, so be sure to read what is under the scale before you mark it. Only mark on the line, not between them, and be sure to answer every question."

(During this narrative the receptionist is pointing to the various items and spaces as he talks about them.)

"Do you have any questions?"

"This next questionnaire is very different from the first. Even though it looks very much the same, it is asking a very different question. Let's read the instructions together. Now imagine that someone in your company, note here that this is not you but one of the men in your unit, is suffering from one of the problem areas listed below, and that he comes to you with the request that you refer him to a counselor for help. On the scale below each problem area, put an "X" in one of the spaces to indicate how likely it is that you would recommend to this friend that he see the counselor you have just seen,

that's Captain Klugman, in order to get help with this problem. Here again, as on the last questionnaire, you are to mark the scale with an "X", and be very careful that you read what you're marking since the scales are mixed up."

"Let me again remind you of the difference between the two questionnaires. On the first, the question is IF YOU had one of the problems how likely is it that YOU would come to see Captain Klugman for help with that problem? On the second questionnaire we are assuming that one of your FRIENDS does have one of the problems, and he ASKS YOU to tell him where he might go to seek help. On this second questionnaire you are to decide how likely it is that you would reply to him, 'I saw a counselor at CMHA by the name of Captain Klugman, who I think may be able to help you with your problem.'" (During the above narrative the receptionist will be pointing to the appropriate places on the questionnaire.)

"When you have finished, please fill out this sheet with the requested information about yourself. You will notice there is no place for your name or your social security number. We are interested in your background and your past history, but don't really need to identify you personally. When you have finished, please take the entire package to the front desk, where they will give you a taxi token so you can return to your unit. I wish to thank you very much for your cooperation and assistance."

APPENDIX E  
CONSENT FORM

CONSENT FORM

I \_\_\_\_\_, unit \_\_\_\_\_  
hereby attest that I have read a written description of the study being conducted at the Fort Dix Community Mental Health Activity that I have been requested to take part in. The written description has fully explained to my satisfaction the requirements, responsibilities, and factors involved in becoming a participant in this research, as well as the fact that any and all contents of my participation in the research shall be held by the Fort Dix Community Mental Health Activity as medically confidential and utilized in such a way as not to lead to my identification. I recognize that my participation in this research is voluntary, and that I have the right to withdraw at any time.

Given these understandings, I hereby freely consent to participate in these studies.

Signature \_\_\_\_\_

Date \_\_\_\_\_

APPENDIX F

DEPENDENT VARIABLE MEASURES



### Personal Improvement Variable

On the scale below put an "X" in one of the spaces after each question to indicate how likely it is that the counselor you have just seen could help you if you were experiencing one or more of the following concerns.

1. A strong fear of not making it through basic training.

____	/	____	/	____	/	____	/	____
Very		/Likely		/Undecided		/Unlikely		/Very
Likely								Unlikely

2. A tendency to "panic" when the drill sergeant yells at you.

____	/	____	/	____	/	____	/	____
Very		/Unlikely		/Undecided		/Likely		/Very
Unlikely								Likely

3. Crying a great deal.

____	/	____	/	____	/	____	/	____
Very		/Likely		/Undecided		/Unlikely		/Very
Likely								Unlikely

4. Being sick and not getting any help at the hospital.

____	/	____	/	____	/	____	/	____
Very		/Unlikely		/Undecided		/Likely		/Very
Unlikely								Likely

5. Feeling that you are "losing your mind".

____	/	____	/	____	/	____	/	____
Very		/Likely		/Undecided		/Unlikely		/Very
Likely								Unlikely

6. Concerns about sexual problems.

____	/	____	/	____	/	____	/	____
Very		/Unlikely		/Undecided		/Likely		/Very
Unlikely								Likely

7. Feeling very sad most of the time.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

8. Not knowing why you do some things.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

9. Conduct that gets you into trouble with other people.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

10. Feelings that you are "different" or that others are out to get you.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

11. Getting angry.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

12. Feeling exhausted or worn out.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

13. Feeling afraid.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

14. Having strange ideas and ways of acting.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

15. Being over excited with too much energy.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

16. Having to depend too much on other people and not being able to make up your own mind.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

17. Behavior and interests that a male should not have.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

18. Feeling worried.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

19. Problems with feeling nervous or shaky inside.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

20. Having emotional problems.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

21. Being unable to get rid of bad thoughts or ideas.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

22. Feeling critical of others.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

23. Having bad dreams.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

24. Difficulty speaking when you are excited.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

25. Feeling easily annoyed or irritated.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

26. Thoughts of ending your life.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

27. Trembling.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

28. Feeling confused.

_____/	_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely	/Very
Unlikely				Likely

29. Crying easily.

_____/	_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely	/Very
Likely				Unlikely

30. Feeling shy or uneasy with the opposite sex.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

31. Temper outbursts you could not control.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

32. Blaming yourself for things.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

33. Feeling that you cannot get things done right no matter how hard you try.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

34. Feeling lonely.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

35. Feeling no interest in things.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

36. Your feelings being easily hurt.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

37. Feeling others do not understand you or are unsympathetic.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

38. Feeling that people are unfriendly or dislike you.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

39. Having to do things very slowly in order to be sure that you are doing them right.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

40. Feeling inferior to others.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

41. Difficulty in falling asleep or staying asleep.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

42. Difficulty making decisions.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

43. Wanting to be alone most of the time.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

44. Having to avoid certain places or activities because they frighten you.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

45. Your mind going blank.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very Unlikely

46. Feeling hopeless about the future.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very Likely

47. Trouble concentrating.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very Unlikely

48. Feeling sick most of the time even though you know nothing is wrong with you.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very Likely

### Referral Variable

Now imagine that someone in your company is suffering from one of the problem areas listed below, and that he comes to you with the request that you refer him to a counselor for help. On the scale below each problem area, put an "X" in one of the spaces to indicate how likely it is that you would recommend to this friend that he see the counselor you have just seen in order to get help with his problem.

1. He is having difficulty in deciding whether or not to stay in the Army.

_____/	_____/	_____/	_____/	_____/
Very Likely	/Likely	/Undecided	/Unlikely	/Very Unlikely

2. He has a very strong fear of the drill sergeants.

_____/	_____/	_____/	_____/	_____/
Very Unlikely	/Unlikely	/Undecided	/Likely	/Very Likely

3. He has difficulty in making or keeping friends.

_____/	_____/	_____/	_____/	_____/
Very Likely	/Likely	/Undecided	/Unlikely	/Very Unlikely

4. He is unable to get to sleep easily or to stay asleep.

_____/	_____/	_____/	_____/	_____/
Very Unlikely	/Unlikely	/Undecided	/Likely	/Very Likely

5. He is concerned about his sexual adjustment.

_____/	_____/	_____/	_____/	_____/
Very Likely	/Likely	/Undecided	/Unlikely	/Very Unlikely

6. He fears that he is losing his mind.

_____/	_____/	_____/	_____/	_____/
Very Unlikely	/Unlikely	/Undecided	/Likely	/Very Likely



7. He has a general feeling of sadness and doesn't know why.

_____/	_____/	_____/	_____/
Very	/Likely	/Undecided	/Unlikely
Likely			Very
			Unlikely

8. He feels very nervous most of the time.

_____/	_____/	_____/	_____/
Very	/Unlikely	/Undecided	/Likely
Unlikely			Very
			Likely

APPENDIX G  
DEPENDENT VARIABLE SCORE MATRIXES

Personal Improvement Variable Score Matrix

TEST ITEM	SUBJECT									
	1	2	3	4	5	6	7	8	9	10
1	4	1	5	1	2	5	1	3	3	3
2	3	3	5	2	2	4	3	2	2	3
3	3	3	1	1	2	2	1	2	3	1
4	2	3	5	1	5	4	2	3	1	5
5	3	5	5	4	2	2	2	3	3	3
6	5	1	1	1	2	2	2	1	3	3
7	4	4	5	2	2	2	2	4	1	2
8	4	3	5	4	4	4	2	4	2	1
9	4	2	5	2	2	1	2	2	3	2
10	4	3	5	5	2	2	2	3	3	2
11	4	3	5	4	4	2	2	3	2	3
12	4	1	5	3	4	3	4	2	3	5
13	4	4	5	2	4	2	2	3	1	2
14	3	3	1	2	2	1	2	4	2	2
15	3	5	1	4	4	2	2	3	3	5
16	2	3	1	4	2	2	2	3	3	2
17	3	3	5	4	4	4	2	1	4	1
18	4	3	5	3	4	2	2	5	1	4
19	4	4	1	4	4	4	2	4	2	3
20	4	4	5	1	4	2	2	3	3	4
21	5	5	1	2	4	4	2	3	3	3
22	3	3	1	4	2	2	2	2	3	2
23	4	1	1	4	4	5	2	3	1	1
24	4	5	1	4	4	2	3	2	1	4
25	4	3	1	2	4	2	3	2	3	4
26	3	5	1	1	4	2	2	2	3	1
27	4	4	1	2	4	2	2	3	3	3
28	4	4	1	4	4	4	3	4	3	4
29	3	5	1	2	2	2	2	3	3	2
30	2	3	1	2	2	4	1	2	3	1
31	4	4	1	1	4	2	2	3	3	3
32	3	3	5	1	4	4	2	4	3	3
33	4	5	5	1	4	4	2	2	3	3
34	4	1	1	2	4	4	3	4	1	3
35	3	3	1	1	2	2	3	3	2	3
36	3	3	1	5	4	3	2	2	3	3
37	3	1	5	4	4	3	2	3	3	2
38	4	2	1	2	4	2	3	3	2	3
39	4	4	5	4	4	4	3	3	3	4
40	3	4	5	2	4	2	3	3	3	3
41	4	4	1	4	4	2	3	4	2	3
42	4	4	1	2	4	2	2	4	3	2
43	2	3	1	2	4	2	2	3	1	2
44	3	4	1	2	4	4	2	2	3	3
45	3	4	1	1	2	2	2	3	2	3
46	4	4	1	2	4	4	2	3	5	2
47	4	3	1	1	4	2	2	4	1	3
48	4	4	1	2	2	4	2	2	1	4

TEST ITEM	SUBJECT									
	11	12	13	14	15	16	17	18	19	20
1	4	3	4	4	5	2	4	2	4	2
2	3	4	3	4	5	2	4	3	5	2
3	3	4	3	4	5	2	3	2	4	2
4	2	5	5	4	5	2	4	4	1	3
5	3	3	1	4	5	2	4	3	3	2
6	5	4	4	4	5	1	2	3	4	3
7	4	4	3	3	5	2	2	4	5	4
8	4	4	4	4	5	3	4	4	3	4
9	4	4	3	4	5	2	4	1	4	2
10	4	4	2	5	5	2	3	2	2	4
11	4	4	3	4	5	3	2	4	4	4
12	4	3	4	5	5	2	2	1	3	5
13	4	4	2	4	5	2	4	4	2	4
14	3	4	2	4	5	2	4	3	3	4
15	3	4	3	5	5	2	3	4	4	3
16	2	4	5	2	5	2	4	2	4	3
17	3	4	3	4	5	1	4	2	4	2
18	4	5	4	4	5	4	4	4	3	4
19	4	4	1	4	5	4	4	4	4	4
20	4	4	3	4	5	2	3	4	3	2
21	5	4	4	4	5	4	4	3	4	4
22	3	4	4	4	5	2	4	3	4	2
23	4	3	2	2	4	1	3	3	4	2
24	4	4	5	4	5	2	4	4	2	1
25	4	4	3	2	5	2	4	3	4	3
26	3	3	2	1	5	4	5	1	4	3
27	4	4	3	4	5	4	3	4	4	4
28	4	4	2	4	5	4	3	5	3	4
29	3	3	3	4	5	2	3	3	4	3
30	2	3	3	4	5	2	3	2	4	2
31	4	3	2	3	5	2	4	4	3	3
32	3	4	3	4	5	2	4	2	3	4
33	4	4	2	4	5	2	4	2	3	4
34	4	3	4	4	5	4	3	5	3	5
35	3	4	4	2	5	2	3	2	3	3
36	3	3	3	2	5	2	3	3	3	2
37	3	4	4	2	5	4	1	3	3	3
38	4	3	4	2	5	2	4	2	3	4
39	4	3	2	2	5	2	2	2	3	4
40	3	4	1	2	5	2	4	3	3	3
41	4	3	1	4	5	2	2	1	3	2
42	4	4	4	2	5	3	3	3	3	2
43	2	4	3	2	5	2	4	3	3	2
44	3	3	3	2	4	2	4	3	5	2
45	3	5	1	2	4	2	4	2	1	2
46	4	4	1	3	5	2	4	1	5	2
47	4	4	2	2	5	2	3	2	1	2
48	4	4	5	2	5	2	3	1	4	4

TEST ITEM	SUBJECT									
	21	22	23	24	25	26	27	28	29	30
1	4	5	5	1	4	1	4	4	3	5
2	4	3	5	1	1	1	3	2	3	5
3	3	4	3	1	3	4	3	3	2	5
4	4	1	1	1	2	1	2	2	3	4
5	1	3	2	1	5	1	2	4	4	5
6	3	1	2	4	2	1	1	2	2	4
7	4	2	4	1	5	5	3	3	3	3
8	4	3	5	2	1	1	3	2	4	4
9	4	2	4	5	1	1	4	2	4	5
10	3	1	4	1	3	3	2	2	3	4
11	4	4	4	4	3	5	2	2	4	2
12	2	5	1	5	1	4	2	4	5	2
13	3	4	4	1	3	3	2	4	3	5
14	4	4	3	1	2	4	1	4	3	4
15	3	1	4	2	2	3	2	4	3	3
16	4	3	2	1	2	1	2	3	3	5
17	4	1	4	1	4	1	2	4	3	5
18	4	5	5	4	3	3	4	3	3	5
19	4	5	4	4	5	5	3	2	4	5
20	4	4	3	1	2	2	2	2	4	4
21	4	4	3	4	3	4	3	2	4	4
22	4	3	4	3	2	3	2	2	4	4
23	3	4	1	2	2	2	1	3	4	5
24	1	3	4	2	2	4	3	4	3	5
25	4	4	4	3	3	5	2	3	3	4
26	3	3	3	2	3	1	3	2	4	5
27	4	4	3	2	3	3	4	3	4	3
28	4	4	4	4	3	4	2	4	4	5
29	4	4	3	1	3	1	2	4	4	5
30	4	1	3	1	3	3	2	3	3	5
31	3	4	3	4	3	4	3	2	4	4
32	4	3	3	1	3	3	4	3	3	4
33	3	4	4	3	3	3	2	4	3	4
34	4	5	4	4	3	1	4	2	3	3
35	2	4	3	2	3	3	4	2	4	5
36	4	3	4	2	3	3	2	3	3	4
37	3	4	4	3	3	3	3	4	3	5
38	4	2	4	2	3	3	2	3	4	4
39	3	4	4	3	3	3	3	4	4	4
40	4	1	4	2	3	3	3	2	3	4
41	4	4	3	4	3	3	4	3	3	4
42	4	4	4	2	3	3	4	3	3	5
43	4	5	4	2	3	3	3	4	3	4
44	4	5	4	2	3	1	1	2	3	5
45	4	1	4	2	3	3	1	4	3	5
46	4	3	5	2	3	2	3	3	3	5
47	3	4	5	2	3	1	3	3	3	4
48	4	3	4	2	3	4	3	2	4	5

TEST ITEM	SUBJECT									
	31	32	33	34	35	36	37	38	39	40
1	4	4	4	3	1	4	5	4	1	5
2	4	5	4	3	3	5	4	4	4	5
3	4	4	2	1	1	2	5	3	1	5
4	5	5	4	5	1	1	2	2	5	3
5	4	4	4	2	1	1	5	4	1	4
6	4	4	2	1	2	4	5	4	2	4
7	4	3	4	3	1	2	2	3	2	5
8	4	5	2	2	1	4	5	3	1	4
9	5	4	4	2	1	1	5	4	1	4
10	4	5	2	2	1	2	5	4	5	5
11	4	1	2	4	5	4	5	2	3	5
12	4	2	3	4	5	5	5	2	5	4
13	4	4	4	3	1	2	2	3	3	5
14	4	4	4	2	1	5	5	4	5	4
15	4	5	2	3	2	4	5	3	5	3
16	4	4	2	3	1	2	1	4	5	4
17	5	5	2	1	3	3	5	3	3	4
18	4	4	4	3	3	1	1	4	2	5
19	4	4	4	3	4	5	1	2	3	5
20	4	4	4	3	4	4	3	3	3	5
21	4	5	4	3	2	3	5	3	3	5
22	4	4	4	3	3	5	1	2	3	4
23	4	3	2	2	1	5	1	3	4	4
24	4	3	2	3	5	1	1	3	1	4
25	4	4	4	3	3	5	1	3	3	4
26	4	5	2	1	1	4	5	4	1	4
27	4	4	3	1	4	1	3	4	1	5
28	4	4	4	4	2	5	1	4	1	4
29	4	5	3	1	1	2	5	3	4	4
30	4	5	2	1	4	1	3	3	5	5
31	4	4	4	1	3	2	5	3	1	4
32	4	5	4	2	2	2	5	4	1	4
33	4	5	4	3	1	3	4	4	1	4
34	4	4	4	3	4	2	1	5	1	4
35	4	5	2	3	1	3	4	4	1	4
36	4	1	4	2	4	3	1	4	1	4
37	4	5	2	3	1	4	4	4	3	3
38	4	5	4	2	1	1	4	4	3	4
39	5	5	4	3	1	4	1	2	2	4
40	4	5	4	3	4	3	3	4	5	4
41	4	4	2	2	1	4	1	3	4	3
42	4	5	4	3	2	3	2	3	1	4
43	4	5	2	2	5	3	2	3	4	4
44	4	5	4	2	1	1	4	3	3	4
45	4	4	4	1	1	4	2	3	1	3
46	4	5	2	2	1	2	4	4	1	4
47	4	5	4	3	1	3	3	3	1	4
48	4	5	4	3	1	1	4	3	1	4

TEST ITEM	SUBJECT									
	41	42	43	44	45	46	47	48	49	50
1	5	4	4	5	4	4	3	1	1	1
2	3	4	3	5	4	3	1	1	5	1
3	2	4	4	5	4	4	2	1	4	1
4	2	3	1	5	4	4	2	3	3	2
5	2	4	5	5	4	4	2	1	5	1
6	3	3	3	5	3	2	2	2	4	3
7	2	4	3	5	4	3	4	2	2	5
8	3	4	4	5	4	2	3	4	5	1
9	2	4	3	5	4	3	2	3	2	4
10	1	4	4	5	4	4	5	2	5	1
11	4	5	4	5	4	4	4	4	3	4
12	4	2	2	1	3	2	4	5	4	4
13	4	3	4	5	4	4	2	3	3	1
14	1	3	3	5	4	4	4	5	4	1
15	4	3	2	5	3	2	4	2	2	2
16	1	3	4	5	4	4	2	1	5	1
17	1	3	4	5	4	2	3	1	5	4
18	4	4	4	5	4	2	2	5	3	4
19	3	4	5	5	4	4	2	1	4	4
20	3	4	4	5	4	3	2	2	5	4
21	4	4	3	5	4	4	2	2	5	1
22	4	3	3	5	4	4	2	2	4	2
23	4	3	2	5	3	2	2	3	1	4
24	4	4	2	1	3	5	3	1	1	4
25	4	3	3	5	4	3	2	3	1	4
26	1	5	4	5	4	2	2	1	1	1
27	4	4	2	5	3	2	2	1	1	3
28	4	4	5	5	4	2	4	4	3	5
29	1	4	1	5	4	2	2	2	1	2
30	2	3	1	1	4	5	2	5	1	4
31	3	4	3	5	3	4	4	2	1	4
32	4	4	3	5	4	4	3	2	2	4
33	3	3	4	5	4	4	4	2	1	4
34	4	3	4	1	4	3	4	2	3	4
35	3	4	2	1	4	4	2	2	1	1
36	3	4	4	5	4	5	2	2	4	2
37	4	3	1	5	4	3	4	2	3	1
38	4	3	2	5	4	2	2	3	1	1
39	4	4	2	5	4	2	4	3	2	4
40	4	3	2	3	4	2	3	2	1	1
41	4	4	3	5	3	2	3	2	1	4
42	4	4	2	5	4	4	3	2	3	4
43	4	3	3	5	3	3	4	2	3	1
44	4	3	3	5	4	4	3	2	1	1
45	3	3	4	5	3	3	2	1	1	4
46	2	4	4	5	4	5	3	1	1	4
47	4	3	4	1	3	4	3	1	1	2
48	3	4	5	5	4	3	2	1	1	5

TEST ITEM	SUBJECT						
	51	52	53	54	55	56	57
1	3	4	5	4	2	1	5
2	4	2	3	3	4	1	1
3	4	2	4	1	2	1	5
4	1	4	4	3	4	1	4
5	3	2	4	4	2	1	4
6	1	4	2	3	1	1	1
7	2	2	5	3	3	1	2
8	4	4	5	2	2	1	2
9	3	1	2	4	2	1	1
10	4	2	4	2	3	1	2
11	4	4	5	3	4	1	4
12	4	4	4	4	4	1	4
13	4	1	4	4	4	1	2
14	3	2	4	3	4	1	2
15	3	2	4	1	3	3	2
16	2	4	5	2	2	1	2
17	1	4	2	2	1	1	1
18	5	4	4	4	4	1	2
19	4	4	5	4	4	2	2
20	2	4	4	4	4	1	2
21	3	1	1	3	4	2	2
22	3	2	3	4	2	1	2
23	4	2	3	4	2	2	1
24	2	2	2	2	4	2	1
25	4	2	2	2	3	2	3
26	1	1	1	5	1	1	1
27	4	4	1	4	4	4	2
28	4	4	4	4	4	2	2
29	4	1	2	4	2	5	2
30	1	2	4	1	2	2	1
31	4	1	2	3	2	1	2
32	3	2	1	4	2	2	2
33	2	4	4	5	4	1	1
34	4	5	4	4	2	1	2
35	2	2	3	3	2	1	2
36	4	4	2	3	2	2	2
37	2	4	2	3	2	1	2
38	4	4	1	3	4	2	2
39	4	4	4	4	3	2	2
40	2	1	3	4	3	1	3
41	3	4	4	4	2	2	2
42	2	1	4	4	4	2	2
43	3	1	1	3	2	2	2
44	2	2	2	3	2	1	2
45	2	1	1	4	2	1	2
46	2	2	2	1	3	1	1
47	2	2	4	1	3	2	2
48	2	1	4	1	2	1	2



Referral Variable Score Matrix

TEST ITEM	SUBJECT									
	1	2	3	4	5	6	7	8	9	10
1	4	5	5	4	4	2	4	5	5	3
2	4	1	5	5	4	2	4	5	1	5
3	3	3	2	3	2	2	4	3	3	4
4	3	5	2	1	4	2	4	3	2	2
5	5	3	5	1	2	2	4	4	5	5
6	4	5	5	4	2	2	4	5	5	1
7	4	5	5	4	4	2	4	3	3	3
8	4	5	5	2	4	2	4	3	1	4

TEST ITEM	SUBJECT									
	11	12	13	14	15	16	17	18	19	20
1	3	4	2	2	4	4	4	3	3	1
2	3	5	3	2	5	4	2	2	4	4
3	3	4	4	3	4	4	4	4	3	4
4	3	5	2	3	4	4	3	4	4	5
5	2	4	4	5	4	4	4	5	2	3
6	3	4	1	2	5	4	4	5	4	4
7	4	4	1	4	5	4	4	3	2	3
8	4	5	1	2	4	4	4	4	4	4

TEST ITEM	SUBJECT									
	21	22	23	24	25	26	27	28	29	30
1	4	4	5	2	1	3	4	4	4	5
2	3	2	5	2	3	3	4	4	4	5
3	2	4	4	5	3	3	3	2	3	5
4	4	4	4	4	3	3	2	2	4	4
5	4	5	4	5	3	3	3	2	4	5
6	4	5	5	4	3	5	3	2	4	5
7	4	3	4	2	3	4	2	2	4	5
8	4	2	4	2	3	4	4	2	4	4

TEST ITEM	SUBJECT									
	31	32	33	34	35	36	37	38	39	40
1	4	3	5	4	1	2	2	5	5	5
2	4	5	4	4	1	5	4	5	1	5
3	4	3	4	3	1	3	3	4	1	4
4	4	4	2	3	1	5	1	3	4	4
5	5	3	5	3	2	3	3	3	1	3
6	4	4	5	3	1	4	5	5	1	4
7	4	4	4	4	2	3	4	1	1	4
8	5	5	4	3	1	2	3	3	1	4

TEST ITEM	SUBJECT									
	41	42	43	44	45	46	47	48	49	50
1	4	4	4	5	2	4	3	1	5	2
2	4	4	4	5	2	4	4	5	5	2
3	5	3	3	5	2	4	2	1	5	4
4	3	2	2	5	2	3	4	5	3	4
5	3	2	5	5	1	4	4	3	5	4
6	5	4	4	5	2	5	5	4	5	4
7	5	5	2	5	4	2	4	4	4	1
8	4	5	4	5	4	2	4	2	4	5

TEST ITEM	SUBJECT										
	51	52	53	54	55	56	57	58	59	60	61
1	4	1	5	4	2	1	2	5	5	4	5
2	4	5	1	4	4	2	4	5	2	4	4
3	4	5	4	2	2	2	3	5	4	4	3
4	4	5	1	3	2	2	4	3	3	4	3
5	4	4	3	1	2	2	1	3	5	4	4
6	5	1	4	1	4	2	4	3	1	4	5
7	4	2	1	3	4	2	2	3	4	4	4
8	4	5	4	3	4	2	4	3	1	4	4

APPENDIX H

SUMMARY TABLES OF CONFEDERATE EFFECTS

Table H-1  
Summary Table of Confederate Effects:  
Personal Improvement Variable

Source	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>
Confederate (A)	1072	2	536.0	.70
A x Setting (B)	67	2	33.5	.04
A x Dress (C)	941	2	470.5	.61
A x Style (D)	1513	2	756.5	.98
A x B x C	362	2	181.0	.24
A x B x D	456	2	228.0	.30
A x C x D	2415	2	1207.5	1.57
A x B x C x D	265	2	132.5	.17
Error	18470	24	769.6	

Table H-2  
Summary Table of Confederate Effects:  
Referral Variable

Source	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>
Confederate (A)	4.5	2	2.3	.14
A x Setting (B)	3.3	2	1.7	.10
A x Dress (C)	2.5	2	1.3	.08
A x Style (D)	138.8	2	69.4	4.26*
A x B x C	9.1	2	4.6	.28
A x B x D	40.5	2	20.3	1.25
A x C x D	75.3	2	37.7	2.31*
A x B x C x D	26.5	2	13.3	.82
Error	390.0	24	16.3	

\*  $p < .20$

APPENDIX I

MEAN SUMMARY TABLES:

PERSONAL IMPROVEMENT VARIABLE

Table I-1  
Mean Summary Table of Dress X Style:  
Personal Improvement Variable

	Lab Coat	Uniform	
Directive	180.42	174.09	177.25
Non-directive	162.75	153.75	158.25
	171.59	163.92	



Table I-2  
Mean Summary Table of Setting X Style:  
Personal Improvement Variable

	Credentials	No Credentials	
Directive	172.17	182.34	177.25
Non-directive	160.5	156.0	158.25
	166.34	169.17	

Table I-3  
Mean Summary Table of Dress X Setting  
Personal Improvement Variable

	Lab Coat	Uniform	
Credentials	172.42	160.25	166.34
No credentials	170.75	167.59	169.17
	171.59	163.92	

Table I-4  
 Mean Summary Table of Dress X Setting X Style:  
 Personal Improvement Variable

	Lab Coat		Uniform	
	Credentials	No credentials	Credentials	No credentials
Directive	180.83	180.0	163.5	184.67
Non-directive	164.0	161.5	157.0	150.5
	172.42	170.75	160.25	167.59
				177.25
				158.25

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## BIOGRAPHICAL SKETCH

Peter Jay Klugman was born in Brooklyn, New York, on May 19, 1942. He was graduated from Midwood High School in June, 1960, and from there went to the University of Miami. At the University of Miami he earned a Bachelor of Arts degree in 1964 and a Master of Education degree in 1965. He was selected for membership in Omicron Delta Kappa and was included in Who's Who Among Students in American Colleges and Universities. In 1972 he entered the University of Florida, where he earned a Master of Arts degree in 1974.


Major Klugman entered the United States Army Medical Service Corps in 1966. He has served in the Federal Republic of Germany, the Republic of Vietnam, and the continental United States. Major Klugman has been awarded the Bronze Star, two Army Commendation Medals, the Purple Heart, the Vietnamese Technical Service Medal, various other personal awards, and the Meritorious Unit Citation and the Vietnamese Cross of Gallantry as unit awards. He is currently the Chief of the Fort Dix Community Mental Health Activity.

Major Klugman is married and has two daughters and one son, ranging in age from eight to twelve.


I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

  
Benjamin Barger, Chairman  
Professor of Clinical Psychology


I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

  
Louis D. Cohen  
Professor of Clinical Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

  
Audrey S. Schumacher  
Professor of Clinical Psychology

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Vernon D. Van de Riet  
Associate Professor of  
Clinical Psychology

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*William B. Ware*

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William B. Ware  
Professor of Foundations  
of Education

This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Sciences and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Dean, Graduate School